2.7 | Regional Update
Oceania

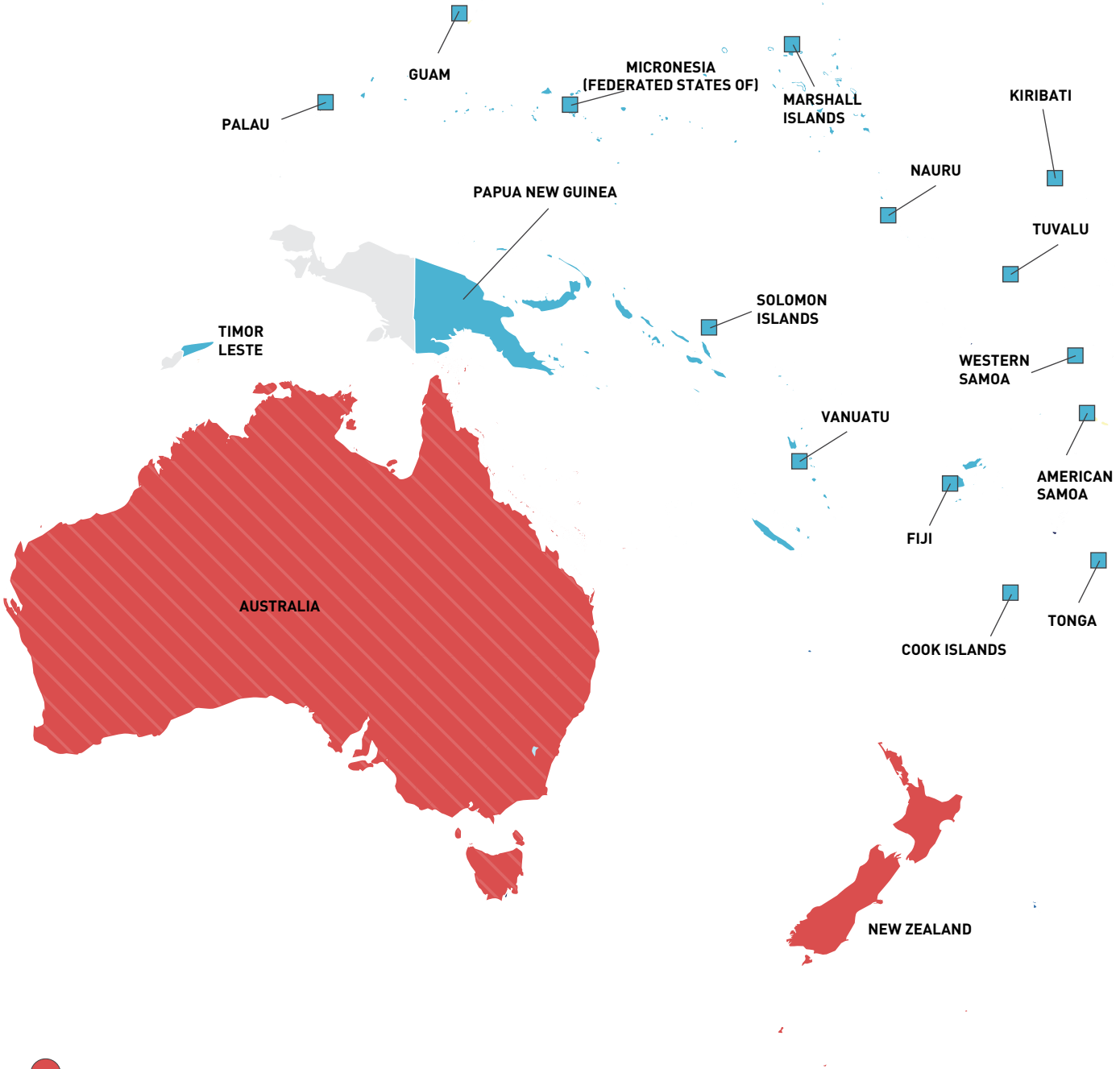
Table 2.7.1: Epidemiology of HIV and Viral Hepatitis, and Harm Reduction Responses in Oceania

Country/territory with reported injecting drug use	People who inject drugs[a]	HIV prevalence among people who inject drugs (%)	Hepatitis C (anti-HCV) prevalence among people who inject drugs (%)[1]	Hepatitis B (anti-HBsAg) prevalence among people who inject drugs (%)[1]	Harm reduction response[b]		
					NSP[c]	OST[d]	DCR[e]
Australia	149,591 (89,253–204,564)	1.0[2]	54.6 (41.2–68)	4 (2.9–5)	✔ (1372) (P)	✔ (2132) (B,M)	✔
Fiji	nk	nk	nk	nk	✖	✖	✖
New Zealand	20,163 (13,535–26,792)	0.4[2]	51.9	2.8 (1.2–4.4)	✔ (>200)[4] (P)	✔ (B,M)	✖
Papua New Guinea	nk	nk	nk	nk	✖	✖	✖
Samoa	nk	0	nk	nk	✖	✖	✖
Timor Leste	nk	nk	nk	nk	✖	✖	✖

nk= not known

a Unless otherwise stated, data are sourced from Mathers B et al. for the Reference Group to the UN on HIV and Injecting Drug Use (2008) Global epidemiology of injecting drug use and HIV among people who inject drugs: a systematic review, *Lancet*, 372(9651):1733 – 1745.
b Unless otherwise stated, data on NSP and OST coverage are sourced from Mathers B, Degenhardt L, Ali H, Wiessing L, Hickman M, Mattick RP, Myers B, Ambekar A & Strathdee SA for the Reference Group to the United Nations on HIV and Injecting Drug Use (2010) HIV prevention, treatment and care for people who inject drugs: A systematic review of global, regional and country level coverage, *Lancet*, 375(9719):1014–28.
c The number in brackets represents the number of operational NSP sites, including fixed sites, vending machines and mobile NSPs operating from a vehicle or through outreach workers. (P) = needles and syringes reported to be available for purchase from pharmacies or other outlets, and (NP) = needles and syringes not available for purchase.
d The number in brackets represents the number of operational OST programmes, including publicly and privately funded clinics and pharmacy dispensing programmes. (M) = methadone, (B) = buprenorphine, (BN) = buprenorphine-naloxone combination, (O) = any other form (including morphine and codeine).
e DCR = Drug consumption room, also referred to as safer injection facility (SIF).
f This figure represents the number of sites in two Canadian provinces: British Columbia and Quebec. The number of sites in other provinces was not known at publication in July 2012.

Map 2.7.1: Availability of needle and syringe exchange programmes (NSP) and opioid substitution therapy (OST)



Harm Reduction in Oceania

The Oceania region includes Australia, New Zealand and the Pacific island countries and territories (PICTs).[g] There are approximately 170,000 people who inject drugs (PWID) in Australia and New Zealand combined, a low proportion of whom (0.4–1.0%) are living with HIV,[2] and over half of whom have hepatitis C (HCV).[1] The prevalence of injecting drug use (IDU) is higher and accounts for a greater proportion of HIV transmission (18%) among Aboriginal Australians than among non-Aboriginals (3%).[3] Few recent, reliable and representative data exist on population size estimates of people who use and inject drugs, or on the prevalence of blood-borne viruses and other drug-related harms in the PICTs.[4]

Although the early implementation of harm reduction programmes in Australia has been widely credited with low levels of HIV among injecting populations, available evidence points to significant ethnic disparities and uneven coverage regionally and among affected groups. No significant changes have occurred in Australia or New Zealand in terms of harm reduction service coverage since 2010. Civil society reports suggest that engagement with the federal and some state governments in Australia has become increasingly challenging around issues such as the need for increased funding for needle and syringe exchange programmes (NSPs), diversification of opioid substitution therapy (OST) options including heroin-assisted treatment and improvement in the range of service provision for people who inject drugs other than heroin.[5] Culturally sensitive, integrated services targeting Aboriginal and Torres Strait Islander Australians, particularly in remote and rural areas, and the meaningful involvement of these communities in service delivery and evaluation, remain important gaps.[3]

With the exception of Papua New Guinea, which has a generalised HIV epidemic, epidemics in the PICTs have remained small.[6] IDU is a minor route of transmission in this sub-region. For instance, in French Polynesia approximately 12% of the cumulative reported HIV cases have been attributed to IDU.[7] Poly-drug use, particularly involving alcohol – both legally and illegally produced homebrew – as well as cannabis, inhalants, kava (for example, on Samoa, Tonga and Vanuatu) and emerging markets for amphetamine-type stimulants, are more common in the PICTs than injecting drug use.[4] Anecdotal evidence indicates that levels of licit and illicit drug use and the availability of new drugs may be increasing in the region.[8]

Responses to drug and alcohol use in the PICTs have relied largely on abstinence-based approaches and law enforcement methods focused on supply reduction. Some broader public-health-focused approaches, including multisectoral education and awareness campaigns and integration of drug services with the mental health system, have been implemented to some degree in individual Pacific island states.[4] However, these have not been systematically evaluated, and a clear framework for addressing drug use in this sub-region is yet to be developed.

The engagement of civil society organisations (CSOs) and organisations of people who use drugs is integral to the harm reduction response in Australia. In the PICTs, the lack of resources and of reliable, active data collection continue to pose barriers to understanding the extent of drug use and designing appropriate policies and responses.

Developments in harm reduction implementation

Needle and syringe programmes (NSPs)

There are over 1372 NSP outlets across Australia operating through a diverse range of service provision models such as needle-syringe vending machines and pharmacy-operated sites. Approximately 203 syringes per person per year were distributed to PWID in 2011.[9] The low rate of HIV among PWID in Australia has often been attributed to the early implementation and scale-up of NSPs. Recent cost-effectiveness analyses have estimated that between 2000 and 2009 over 32,000 HIV infections were averted, and for every $1 invested in NSPs $4 were returned in health care cost savings.[10] Along with Australia, New Zealand has one of the highest NSP coverage rates in the world, having distributed 2.7 million needle-syringes from the approximately 200 outlets across the country at an estimated rate of 270–280 needle-syringes per person per year.[2]

Despite relatively high coverage rates by international standards,[h] recent estimates indicate that only 12.4% of PWID in Australia and 70% in New Zealand reported using sterile injecting equipment the last time they injected.[2] Evidence suggests that the use of non-sterile equipment and re-use of injecting paraphernalia may be relatively high among key sub-groups of PWID, such as Aboriginal Australians, who also tend to experience a multiplicity of health and socio-economic disparities compared with their non-Aboriginal counterparts.[3] Access to NSP services by these groups is limited by inadequate provision in remote and rural areas, the lack of culturally sensitive service delivery or service models that recognise the Aboriginal definition of health[i] and

g The PICTs comprise 22 countries and territories subdivided into Micronesia, Polynesia and Melanesia. They are American Samoa, Cook Islands, Federated States of Micronesia, Fiji, French Polynesia, Guam, Kiribati, Marshall Islands, Nauru, New Caledonia, Niue, Northern Mariana Islands, Palau, Papua New Guinea, Pitcairn Islands, Samoa, Solomon Islands, Tokelau, Tonga, Tuvalu, Vanuatu, and Wallis and Futuna.

h The 2009 WHO, UNAIDS, UNODC *Technical Guide for countries to set targets for universal access to HIV prevention, treatment and care for injecting drug users* categorises NSP coverage levels as follows: low (<100 needles/syringes per injector per year), medium (>100–<200 needles/syringes per injector per year) and high (≥200 needles/syringes per injector per year).

i Aboriginal community-controlled health services (ACCHS) in Australia consider three different social dimensions: the individual, the family, and the community. For more information, see Australian National Council on Drugs (2011) *Injecting drug use and associated harms among Aboriginal Australians*. Canberra: Australian National Council on Drugs.

stigma and discrimination by the community and by medical personnel.[3, 10]

A recent survey by the Australian Injecting and Illicit Drug Users' League (AIVL) found that not only does much of the general population discriminate against people who use drugs (PWUD), but many feel that discrimination may deter people from using drugs, and as such is a positive event.[11] Additional barriers to access are posed by legislation limiting the distribution of injecting equipment.[12] For example, it is illegal for a person to provide injecting equipment to a peer, which often translates into services placing limits on the amount of equipment distributed per person. The limited range of equipment supplied at NSPs is also a challenge in many states in Australia, particularly for people injecting drugs other than heroin. In most states, for example, equipment such as sterile water, large-sized barrels, filters and winged-tip syringes are not supplied by state health departments, and service users must purchase them from pharmacies or other suppliers.[10]

NSPs do not operate in any PICTs, and it is not known whether needle-syringes can be purchased from pharmacies in these settings. Where drug and alcohol services for PWUD exist, these tend to be abstinence-based and are often located within mental health services.[4]

Legal status for Australia's only medically supervised injecting centre

Australia's only medically supervised injecting centre (MSIC) originally began operating for a trial period of 18 months in Sydney in May 2001 and continued to operate as a 'trial' project for over a decade, during which it underwent numerous evaluations.[13] The MSIC has provided sterile injecting equipment for use alongside a range of additional services to all people who inject drugs, with the exception of pregnant women who inject drugs or young people under the age of 18.[5]

On 1 November 2010 the MSIC was ultimately awarded legal status through the enactment of the Drug Misuse and Trafficking Amendment (Medically Supervised Injecting Centre) Bill 2010 into law.[14] This allows the facility to operate as other health services – without requiring an extension from the State Parliament to continue operation every four years. Although the MSIC has strong support within the local community, plans to trial or open similar facilities are not currently on the agenda anywhere else in Australia.

Opioid substitution therapy

Over 2132 outlets provide OST across Australia.[7] A key change in the provision of OST in Australia since 2010 has been the introduction of buprenorphine-naloxone film to replace buprenorphine and buprenorphine-naloxone combination pills for substitution therapy.[5] Presently, pills are being phased out over a two-year period, following which they will cease to be covered through the government scheme. However, some clinics, pharmacies and doctors have reportedly been forcing a shift to the film without prior consultation or patient involvement in the decision.[5]

As reported in 2010, a major barrier to accessing OST remains the cost prescribed by dispensing pharmacies and private clinics,[j] with people on OST paying between A$40 and A$85 per week for the medication.[15] Qualitative research has shown that the high costs of OST services may compel some people to choose between basic necessities such as food and their medication, while others report engaging in crime or selling takeaway doses to pay for OST.[13] While demand for OST has increased in Australia in recent years, the availability of treatment has remained the same, resulting in frequent delays and waiting lists, particularly in remote and rural areas.[16] In some regions, where one prescribing doctor or dispensing pharmacist often covers a wide geographical area, clients have reported travelling more than two hours daily or several times per week to access OST.[5] Pregnant women and women with children who use opiates are often hesitant to access services for fear that Child Protection Services may potentially take their children into protective care.[5] Guidelines for prescribing and administering pharmacotherapies in Australia were being reviewed at the time of writing.

In New Zealand, approximately 4600 individuals are receiving OST, mostly in the form of methadone.[17] Significant waiting times and restrictions on takeaway doses have been reported among the top three perceived barriers to OST.[11] Resource constraints pose an additional obstacle in the transfer of OST provision from specialist OST sites and its integration into primary care settings.[17]

There is generally a lack of treatment options, and no OST provision, in the PICTs. Existing responses to drug and alcohol use are usually abstinence-based and largely delivered through mental health and counselling programmes.[4] A 2008–9 situational analysis by the Burnet Institute identified a focus on prevention-focused education and training programmes around drug and alcohol use for young people; however, it is unclear whether these interventions have had an impact on behaviour change in the sub-region, and there has been little evaluation of their effectiveness.[4]

j Methadone and buprenorphine are provided free to pharmacies and clinics in Australia by the federal government under the Pharmaceutical Benefits Scheme (PBS). These services then charge the client for dispensing, often charging more for takeaway doses.

Antiretroviral therapy

HIV prevalence among PWID remains low in Australia (1.0%) and New Zealand (0.4%) (see Table 2.7.1). However, the drug-related HIV burden is not consistent across sub-groups of injectors. In 2011, a higher proportion of HIV cases among Aboriginal and Torres Strait Islander people (19.4%) were attributed to IDU compared with new HIV diagnoses among non-Indigenous people (2.5%),[7] and HIV rates within these sub-populations who inject drugs are high by comparison. It is estimated that in Australia the total number of people prescribed antiretroviral therapy (ART) increased from 9463 in 2006 to 11,523 during 2010.[10] It is unclear how many of these people are PWID.

New data indicate that almost half (47.6%) of PWID in Australia accessed HIV testing in the last year. This proportion is lower than in New Zealand, where 80% of PWID reported having an HIV test in 2009.[2]

In 2010, Australasia was reported to have the second highest level of ART coverage among PWID after Western Europe.[18] Papua New Guinea, Fiji, Timor Leste and states in Micronesia provide ART, but it is unknown how many PWID living with HIV are receiving treatment.

Viral hepatitis

In contrast to low HIV prevalence among PWID in the region, viral hepatitis rates are high and increasing in key areas of the region. Australia and New Zealand both have HCV rates over 50% among PWID.[1] Liver disease, most commonly as a result of viral hepatitis, has become the most common cause of mortality among ageing people who are dependent on opioids.[19] For example, incidence of HCV among PWID enrolled in the Hepatitis C Incidence and Transmission Study community (HITS-c) in Sydney increased from 5.0 per 100 person years in 2009 to 9.3 in 2010.[10] In some regions, such as South Australia and Western Australia, levels of HCV are substantially higher in the Aboriginal and Torres Strait Islander population than in the non-Aboriginal population.[10]

Hepatitis B (HBV) prevalence among PWID has remained stable over the past decade – 2.8% in New Zealand and 4% in Australia, according to a 2011 systematic review.[1] Surveillance studies show that there has been an increasing number of newly diagnosed HBV cases among Aboriginal Australians, despite vaccination programmes,[3] with IDU reported as the most frequent source of exposure.[10]

Targeted, integrated HIV and viral hepatitis programmes operate free of charge across Australia and are particularly common in capital cities. Despite high levels of provision, the AIVL estimates that less than 10% of people living with chronic HCV access treatment every year.[20] Barriers to HCV testing and treatment among PWID include stigma and discrimination in the health care sector, lack of housing, treatment and post-treatment support.[5]

In Christchurch, where the largest population of PWID in New Zealand resides, a specialised pilot programme dedicated solely to addressing HCV testing, treatment and support has operated since January 2009, enrolling more than 530 clients as of November 2011.[21] The Christchurch Hepatitis C Community Clinic operates as an integrated model attached to an NSP and liaises with various local agencies, including OST programmes, hospitals offering antiviral therapy and general practitioners (GPs). Its low-threshold services and accessible community setting have attracted PWID who may feel stigmatised by mainstream health services.

Little is known about the prevalence of viral hepatitis in the PICTs. HBV is highly endemic in Tonga, where more than 10% of the population is estimated to have active HBV infection.[22] The WHO Western Pacific Regional Office (WHO-PRO) has also documented HBV in Guam, Kiribati, Solomon Islands, Fiji, Vanuatu, New Caledonia, Federated States of Micronesia and Samoa.[23] Low HCV prevalence has previously been recorded among Samoans and American Samoans, with tattooing practices potentially contributing to infection.[24] It is unclear what role drug and alcohol use plays in the viral hepatitis context in the PICTs.

Tuberculosis

The incidence of tuberculosis (TB) cases is low at between 5–6 cases per 100,000 people in Australia, or 1062 bacteriologically confirmed cases of TB in 2009.[25] Incidence rates in New Zealand are higher than those in Australia at around 10 per 100,000 people, representing approximately 350–400 cases per year.[26] Foreign-born individuals are disproportionately affected: for instance, all cases of multidrug-resistant TB (MDR-TB) in Australia in 2009 were among individuals from Papua New Guinea and the Torres Strait Islands cross-border region, and over two-thirds of all TB cases in New Zealand are in foreign-born individuals, particularly among people from the PICTs. It is estimated that 11,000 people across 22 PICTs acquire TB every year, 50% of whom are infectious cases.[27]

It is not known what proportion of PWID across the region have had TB diagnosed and treated successfully, or to what extent TB/HIV co-infection occurs among PWUD.

Overdose

A recent meta-analysis showed that among other world regions, Australasia had the lowest pooled crude mortality rates (CMRs) among people who use opioids, with overdose reported most commonly as the cause of death.[28] Non-fatal heroin overdose is highly prevalent,[29] while drug overdoses attributed to prescription drugs are overrepresented in remote and rural areas of Australia.[30] Recent evidence has shown the positive effect of the Sydney MSIC on overdose-deaths: calls to ambulance services to attend to opioid-related overdoses declined significantly in the vicinity of the Sydney safe injecting facility (SIF) after it opened, compared to the rest of New South Wales.[31]

Naloxone is a prescription-only drug administered to reverse the effects of overdose by ambulance paramedics and other medical staff through registered health services in Australia. In late 2011 the first trial piloting distribution of naloxone for peer administration was launched in Canberra.[32] The two-year training programme seeks to make naloxone more widely available by training 200 PWID, their families and friends to respond to drug overdoses. This will include training on the administration of naloxone, which will be funded by the government.[31]

Harm reduction in prisons

Drug use and injecting are common in Australasian prisons. Almost half of participants (48–49%) in the 2011 Australian Needle and Syringe Program Survey reported a lifetime history of imprisonment, and 10% reported incarceration in the last year.[33] One in three (31–37%) of those who reported having been incarcerated in the past year had injected drugs while in prison.[33] Studies have shown that Aboriginal Australians, and Aboriginal women in particular, are overrepresented in prisons and tend to experience elevated rates of HIV, HCV and other blood-borne viruses.[34] Previous research in Australian prisons has suggested that prisoners are more likely to share injecting equipment in custody than people in the general community, and found that HCV rates among prisoners were higher than 20%.[35]

There are currently no NSPs in prisons in the Oceania region. However, OST is available in most Australian and New Zealand prisons. In 2011 the Australian Capital Territory (ACT) government invited public submissions on a proposed NSP trial at the Alexander Maconochie Centre (AMC) in Canberra.[36] At the time of writing, plans to initiate the NSP had been placed on hold amid debates among key stakeholders, with an implementation date yet to be determined.[5]

Policy developments for harm reduction

Although no significant changes to harm reduction policy have occurred at the national level in Australia, the debate around drug policy reform and decriminalisation has broadened considerably. In response to the Global Commission on Drug Policy's 2010 report,[37] Australia 21,[k] an independent, multidisciplinary NGO, brought together 24 former senior state and federal politicians, experts in drug policy and public health, young people, a business executive and former law enforcement officers to discuss Australia's present drug policy and explore moving toward a decriminalisation approach to illicit drugs. The report that followed the 21 January 2012 high-level roundtable, *The prohibition of illicit drugs is killing and criminalising our children and we are all letting it happen*, has since called for a review of Australia's drug law toward a decriminalisation and regulation approach of illicit drugs.[38] Despite more open debate around drug policy reform, there has been increased interest by some state governments and funders in the 'New Recovery' movement, which in the Australian context has promoted abstinence as an externally enforced goal for people who use opiates, and limits the time period during which a person may be able to access OST.[5]

In 2010, Australia released its Third National Hepatitis C Strategy 2010–2013[39] and accompanying National Surveillance and Monitoring Plan.[40] The inclusion of concrete targets and dedicated resources in the new document is a significant improvement on the previous strategies between 1999 and 2008, as it will allow for monitoring and evaluation of its effectiveness.[41] Targets to be measured include increasing access to sterile injecting equipment through NSPs, and reducing the burden of disease attributed to chronic HCV in Australia.

An extensive review of New Zealand's drug law began in early 2010. In June 2011 an independent, government-funded law advisory body, the Law Commission, tabled in Parliament its final report and 144 recommendations for reforming the Misuse of Drugs Act 1975. The review called the current policy 'outdated' and recommended greater investment in harm reduction, education and addiction treatment, amendment of drug paraphernalia laws and decriminalisation of small amounts of drug possession.[42]

Many of the same concerns as in 2010 are still applicable to the context of the PICTs. Responses to drug use in the region have generally been law-enforcement-centred.[4] However, recent reports have cited the development of a broadening perspective that takes into account public health and development approaches.[4] Increased engagement in the region from agencies such as WHO-PRO, the Secretariat of the Pacific Community (SPC) and the Pacific Drug and Alcohol Research Network (PDARN) have increasingly brought attention to drug and alcohol issues in the PICTs. For instance, a significant concern emerging out of the 2011 meeting of PDARN remains the lack of national frameworks to address the production of homebrew alcohol, which has been linked to increased crime, particularly violence against women.[4, 40] The lack of data and resources to conduct comprehensive research continues to hamper the design and implementation of appropriate policy responses.[43]

k For more information, visit http://www.australia21.org.au.

Civil society developments for harm reduction

Civil society organisations (CSOs) and organisations of people who use drugs have been integral to Australia's harm reduction response at the national and state levels. Although advocacy on behalf of PWUD remains underfunded, the AIVL and its member organisations across the country regularly engage in advocacy within academic, community and policy forums. AIVL recently completed its Online Discrimination Survey as part of the broader National Anti-Discrimination Project which aims to reduce stigma and discrimination, improve access to services and reduce social exclusion among PWID and those on OST.[10] A report summarising the findings and exploring the history of stigma and discrimination against PWUD was published in July 2011.[8]

In August 2011 the New Zealand Drug Foundation and the New Zealand Society on Alcohol and Drug Dependence organised a Drug Policy Symposium that brought together experts from New Zealand and overseas. The aim of the symposium was to engage policymakers and funders in a conversation around integrated and effective treatment for drug dependence in light of the government's commitment to provide additional funding for treatment.[44]

Although civil society in the PICTs has established a more visible presence in recent years, its engagement in regional forums around harm reduction has remained very limited. Activities have largely been hindered by inadequate resources. The Pacific Regional Rights Resource Team (RRRT) is active in the region, providing training, technical support and policy and advocacy assistance on issues of governance, democracy and human rights. PDARN is the only research and information network in the Pacific Region with a specific focus on substance use and related issues. The network first met in 2005 in response to a lack of data describing drug and alcohol issues in the PICTs, and held its most recent meeting in 2011 in Fiji. The gathering brought together government officials, NGOs, representatives from multilateral agencies, researchers and law enforcement representatives to exchange information and collaborate on joint activities.[8] Among the priorities identified for the region are the urgent need for technical and financial support to develop effective national alcohol policies and action plans, the need for adequate funding for conducting comprehensive research to inform responses and the need for ongoing support to strengthen networks within countries and the region.[8]

Multilaterals and donors: developments for harm reduction

Bilateral funds from Australia and New Zealand remain an important source of support in the PICTs.[4] Multilateral agencies such as WHO-PRO have increasingly worked with the SPC and PDARN to improve the level of engagement in the region. The Australian government, through the Australian Agency for International Development (AusAID), is also an important source of bilateral support for HIV and harm reduction programming across Asia and the Pacific.

Support for harm reduction services and for organisations of PWUD in Australia has long been provided by the federal government and state governments, generally via health departments. In the past two years, a competitive funding model has been introduced whereby a larger number of NGOs compete for a smaller pool of funding in one-year cycles, resulting in increasingly insecure funding year to year.[5] The level of funding for harm reduction programmes such as NSPs and OST nationally has remained the same as reported in 2010. No significant changes in funding or support for harm reduction were reported in New Zealand.

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